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Attorney General of California
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7

8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
9 **STATE OF CALIFORNIA**

10 In the Matter of the First Amended Accusation
Against:

11 **ARIA OMAR SABIT, M.D.**
12 **29355 Northwestern Highway, Suite 130**
13 **Southfield, MI 48034**

14 **Physician's and Surgeon's Certificate**
Number A 108433

15 Respondent.

Case No. 05-2011-212383

OAH No. 2013100883

STIPULATED SURRENDER OF
LICENSE AND ORDER

16 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
17 entitled proceedings that the following matters are true:

18 PARTIES

19 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
20 of California (Board). She brought this action solely in her official capacity and is represented in
21 this matter by Kamala D. Harris, Attorney General of the State of California, by Colleen M.
22 McGurrin, Deputy Attorney General.

23 2. ARIA OMAR SABIT, M.D. (Respondent) is represented in this proceeding by
24 attorney Peter R. Osinoff, Esq., whose address is Bonne Bridges Mueller O'Keefe & Nichols,
25 3699 Wilshire Blvd., Tenth Floor, Los Angeles, California 90010-2719.

26 3. On or about June 17, 2009, the Board issued Physician's and Surgeon's Certificate
27 Number A 108433 to ARIA OMAR SABIT, M.D. (Respondent). The Physician's and Surgeon's
28 Certificate was in full force and effect at all times relevant to the charges brought in First

1 Amended Accusation No. 05-2011-212383 and will expire on January 31, 2015, unless renewed.

2 JURISDICTION

3 4. First Amended Accusation No. 05-2011-212383 was filed before the Medical Board
4 of California (Board), Department of Consumer Affairs, and is currently pending against
5 Respondent. The First Amended Accusation and all other statutorily required documents were
6 properly served on Respondent on November 5, 2013. Respondent timely filed his Notice of
7 Defense contesting the First Amended Accusation. A copy of First Amended Accusation No. 05-
8 2011-212383 is attached as Exhibit A and incorporated by reference.

9 ADVISEMENT AND WAIVERS

10 5. Respondent has carefully read, fully discussed with counsel, and understands the
11 charges and allegations in First Amended Accusation No. 05-2011-212383. Respondent also has
12 carefully read, fully discussed with counsel, and understands the effects of this Stipulated
13 Surrender of License and Order.

14 6. Respondent is fully aware of his legal rights in this matter, including the right to a
15 hearing on the charges and allegations in the First Amended Accusation; the right to be
16 represented by counsel, at his own expense; the right to confront and cross-examine the witnesses
17 against him; the right to present evidence and to testify on his own behalf; the right to the
18 issuance of subpoenas to compel the attendance of witnesses and the production of documents;
19 the right to reconsideration and court review of an adverse decision; and all other rights accorded
20 by the California Administrative Procedure Act and other applicable laws.

21 7. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each
22 and every right set forth above.

23 8. Respondent freely, voluntarily, knowingly, and intelligently waives any future right
24 to apply for medical licensure in the State of California, to file a petition for reinstatement of his
25 surrendered license and certificate, and to practice medicine in the State of California.

26 CULPABILITY

27 9. Respondent understands that the charges and allegations in First Amended
28 Accusation No. 05-2011-212383, if proven at a hearing, constitute cause for imposing discipline

1 upon his Physician's and Surgeon's Certificate.

2 10. For the purpose of resolving the First Amended Accusation without the expense and
3 uncertainty of further proceedings, Respondent admits that, at a hearing, Complainant could
4 establish a factual basis for the charges in the Second Cause for Discipline, paragraph 44, as to
5 patient J.S., paragraphs (B) and (D); as to patient M.S., paragraphs (A) and (B); as to patient R.S.,
6 paragraph (C); as to patient D.B., paragraph (C); as to patient M.M., paragraphs (A) and (B); and
7 the Fourth Cause for Discipline in the First Amended Accusation No. 05-2011-212383, and that
8 those charges constitute cause for discipline. Respondent hereby gives up his right to contest that
9 cause for discipline exists based on those charges.

10 11. Respondent understands that by signing this stipulation he enables the Board to issue
11 an order accepting the surrender of his Physician's and Surgeon's Certificate without further
12 process.

13 CONTINGENCY

14 12. This stipulation shall be subject to approval by the Board. Respondent understands
15 and agrees that counsel for Complainant and the staff of the Board may communicate directly
16 with the Board regarding this stipulation and surrender, without notice to or participation by
17 Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he
18 may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board
19 considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order,
20 the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this
21 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not
22 be disqualified from further action by having considered this matter.

23 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
24 copies of this Stipulated Surrender of License and Order, including Portable Document Format
25 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

26 14. In consideration of the foregoing admissions and stipulations, the parties agree that
27 the Board may, without further notice or formal proceeding, issue and enter the following Order:

28 ///

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 108433, issued to Respondent ARIA OMAR SABIT, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order. Respondent shall further lose all future right(s) to apply for medical licensure in California, and to file a petition for reinstatement of his surrendered license and certificate in California.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Peter R. Osinoff, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

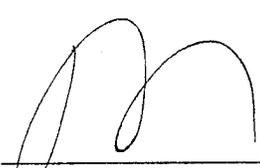
7/29/14



ARIA OMAR SABIT, M.D.
Respondent

1 I have read and fully discussed with Respondent ARIA OMAR SABIT, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.

4
5 DATED: 7/30/14


6 PETER R. OSINOFF, ESQ.
7 Attorney for Respondent

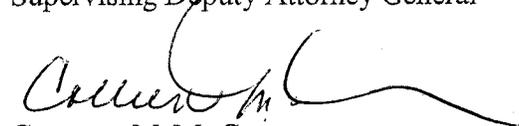
8 ENDORSEMENT

9 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
10 for consideration by the Medical Board of California of the Department of Consumer Affairs.

11
12 Dated: 8/1/14

Respectfully submitted,

13 KAMALA D. HARRIS
14 Attorney General of California
15 ROBERT MCKIM BELL
16 Supervising Deputy Attorney General


17 COLLEEN M. MCGURRIN
18 Deputy Attorney General
19 *Attorneys for Complainant*
20 *Medical Board of California*

21 LA2013607634
22 Final Proposed Stipulated Surrender docx
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Exhibit A

First Amended Accusation No. 05-2011-212383

1 KAMALA D. HARRIS
Attorney General of California
2 ROBERT MCKIM BELI.
Supervising Deputy Attorney General
3 COLLEEN M. MCGURRIN
Deputy Attorney General
4 State Bar Number 147250
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 5, 2013
BY: J. Telech ANALYST

7
8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the First Amended Accusation
Against:

Case No. 05-2011-212383

11 ARIA OMAR SABIT, M.D.
12 29355 Northwestern Highway, Suite 130
13 Southfield, MI 48034

FIRST AMENDED ACCUSATION

14 Physician's and Surgeon's Certificate Number
A 108433

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in
20 her official capacity as the Interim Executive Director of the Medical Board of California,
21 Department of Consumer Affairs.

22 2. On or about June 17, 2009, the Medical Board of California issued Physician's and
23 Surgeon's Certificate Number A 108433 to Aria Omar Sabit, M.D. (Respondent). Said
24 Certificate was in full force and effect at all times relevant to the charges brought herein and will
25 expire on January 31, 2015, unless renewed.

26 **JURISDICTION**

27 3. This First Amended Accusation is brought before the Medical Board of California
28 (Board), Department of Consumer Affairs, under the authority of the following laws. All section

1 references are to the Business and Professions Code unless otherwise indicated.

2 4. Section 2004 of the Code states, in pertinent part:

3 "The board shall have the responsibility for the following:

4 "(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice
5 Act.

6 "(b) The administration and hearing of disciplinary actions.

7 "(c) Carrying out disciplinary actions appropriate to findings made by a panel or an
8 administrative law judge.

9 "(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
10 disciplinary actions.

11 "(e) Reviewing the quality of medical practice carried out by physician and surgeon
12 certificate holders under the jurisdiction of the board.

13 "(f) . . . (i)."

14 5. Section 2220 of the Code states:

15 "Except as otherwise provided by law, the Division of Medical Quality may take action
16 against all persons guilty of violating this chapter [Chapter 5, the Medical Practice Act]. The
17 division shall enforce and administer this article as to physician and surgeon certificate holders,
18 and the division shall have all the powers granted in this chapter for these purposes including, but
19 not limited to:

20 "(a) Investigating complaints from the public, from other licensees, from health care
21 facilities, or from a division of the board that a physician and surgeon may be guilty of
22 unprofessional conduct. The board shall investigate the circumstances underlying any report
23 received pursuant to Section 805 within 30 days to determine if an interim suspension order or
24 temporary restraining order should be issued. The board shall otherwise provide timely
25 disposition of the reports received pursuant to Section 805.

26 "(b) Investigating the circumstances of practice of any physician and surgeon where there
27 have been any judgments, settlements, or arbitration awards requiring the physician and surgeon
28 or his or her professional liability insurer to pay an amount in damages in excess of a cumulative

1 total of thirty thousand dollars (\$30,000) with respect to any claim that injury or damage was
2 proximately caused by the physician's and surgeon's error, negligence, or omission.

3 "(c) Investigating the nature and causes of injuries from cases which shall be reported of a
4 high number of judgments, settlements, or arbitration awards against a physician and surgeon."

5 6. Section 2230.5 of the Code provides, in pertinent part:

6 "(a) Except as provided in subdivisions (b) and (c), and (e), any accusation filed against a
7 licensee pursuant to Section 11503 of the Government Code shall be filed within three years after
8 the board, or a division thereof, discovers the act or omission alleged as the ground for
9 disciplinary action, or within seven years after the act or omission alleged as the ground for
10 disciplinary action occurs, whichever occurs first.

11 "(b)"

12 "(c) An accusation filed against a licensee pursuant to Section 11503 of the Government
13 Code alleging unprofessional conduct based on incompetence, gross negligence, or repeated
14 negligent acts of the licensee is not subject to the limitation provided for by subdivision (a) upon
15 proof that the licensee intentionally concealed from discovery his or her incompetence, gross
16 negligence, or repeated negligent acts."

17 "(d) . . . (f)."

18 7. Section 2227 of the Code provides that a licensee who is found guilty under the
19 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
20 one year, placed on probation and required to pay the costs of probation monitoring, or such other
21 action taken in relation to discipline as the Division deems proper.

22 8. Section 2234 of the Code, provides, in pertinent part:

23 "The board shall take action against any licensee who is charged with unprofessional
24 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
25 limited to, the following:

26 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
27 violation of, or conspiring to violate any provision of this chapter.

28 "(b) Gross negligence.

1 was referred to Respondent for surgical consultation and treatment.

2 12. On or about July 10, 2009, Respondent saw J.S. at VCNA, and documented that the
3 patient had "very severe stenosis² at L1 down to L5." However, the CT lumbar spine post-
4 myelogram³ reports "negative" findings at T12-L1, "no stenosis at L1-2," "mild canal stenosis at
5 L2-3 and L3-4," and no stenosis at L5-S1. The only area of "severe stenosis" was reported at L4-
6 5. Respondent also noted that J.S. had a scoliotic curvature of the spine, however, the lumbar CT
7 myelogram and x-rays do not describe or mention scoliosis.⁴ Respondent recommended surgery
8 from L1 or L2 to L5 or S1, and ordered a discogram⁵ prior to surgery.

9 13. On or about August 7, 2009, Respondent saw J.S. and noted that the discogram was
10 "positive from L3-L4 to L5-S1." The L5-S1 level, however, was not included in the levels to be
11 studied nor was that level injected with contrast dye. Further, there were no demonstrated
12 annular⁶ fissures⁷ at any of the injected levels (i.e., L2-3, L3-4 nor L4-5).

13 14. On or about December 18, 2009, Respondent performed surgery on J.S. at
14 Community Memorial Hospital (CMH). According to Respondent's operative report, he
15 performed a "Posterior lateral fusion L3, L4, L5, S1. Laminectomy⁸ for decompression⁹ L3, L4,
16 L5, S1. Pedicle screw fixation¹⁰ L3, L4, L5. Allograft.¹¹ Autograft.¹² Fluoroscopy.¹³ Repair

17
18 ² Stenosis is the narrowing of the vertebral canal, nerve root canals, or intervertebral foramina of the lumbar spine.

19 ³ A myelogram is an x-ray film taken after the injection of a radiopaque medium into the subarachnoid space to demonstrate any distortions of the spinal cord, spinal nerve roots, and subarachnoid space.

20 ⁴ Scoliosis is a side-to-side curvature of the spine.

21 ⁵ A discogram is an x-ray image produced by a discography. A discography is an examination of the intervertebral disk space using x-rays after injection of contrast media into the disk.

22 ⁶ Annular refers to shaped like or forming a ring.

23 ⁷ Fissure refers to a deep furrow, cleft, groove or slit, normal or otherwise.

24 ⁸ A laminectomy is the surgical removal of the posterior arch of a vertebra.

25 ⁹ Decompression in spinal surgery refers to the surgical relief of pressure on the spinal cord.

26 ¹⁰ Pedicle screw fixation, in orthopedic surgery, refers to a multicomponent device constructed from stainless or titanium-based steel, consisting of solid, grooved, or slotted plates of rods that are longitudinally interconnected and anchored to adjacent vertebrae using bolts, hooks, or screws.

27 ¹¹ An allograft is a graft of tissue obtained from a donor of the same species as, but with a different genetic make-up from, the recipient, as a tissue transplant between two humans.

28 ¹² An autograft is a graft of tissue or organ that is grafted into a new position on the body of the individual from whom it was removed.

¹³ Fluoroscopy is an examination by means of a fluoroscope. A fluoroscope is a device equipped with a fluorescent on which the internal structures of an optically opaque object, such as the human body, may be continuously viewed as shadowy images formed by the different transmission of x-rays through the object.

1 of CSF¹⁴ leak, creation of shunt.”¹⁵ J.S. signed a consent for an L4-5 interbody fusion with
2 decompression and fusion from L3 to S1, however, Respondent’s operative report narrative does
3 not describe that an interbody fusion was performed at L4-5. There is no explanation for this
4 discrepancy documented in the patient’s chart. During an interview with the Board, Respondent
5 stated that he “did not see the consent sheet” and “it was not the practice at the hospital to look at
6 this consent sheet” before the procedure. He further stated “I would have gone off whatever I had
7 in my . . . dictation in my office, whatever I decided I was going to do” and that he “was not
8 going to base [the procedure] on” the consent signed by the patient. Respondent, however, failed
9 to document any explanation for the discrepancies between the actual procedures performed and
10 the procedures listed in the signed patient consent.

11 A). Respondent’s operative report narrative further describes that the instrumentation was
12 inserted from L3 to L5, excluding S1 (the sacrum) from the instrumentation construct. In
13 explaining why the S1 level was not included in the instrumentation construct, Respondent told
14 the Board that there was no need to perform an extensive laminectomy at that level or to expose
15 the nerve roots. However, Respondent’s operation report contradicts this and states that
16 “[l]aminectomies were performed at L3, L4, L5, S1. All nerve roots were exposed.
17 Foraminotomies¹⁶ were done at all levels. Medial facetectomies¹⁷ were also done at all levels.”
18 These procedures, however, are not supported by the post-operative lumbar x-ray which notes
19 reports a laminectomy at L4.

20 B). Respondent’s operative report narrative further states that a “posterolateral fusion was
21 . . . performed at L3, L4, L5, S1.” However, this is not supported by the post-operative lumbar
22 spine x-ray reports which notes a posterior fusion from L3 to L5. Respondent failed to
23 accurately dictate the procedures he performed during the operation and failed to correct his
24

25 ¹⁴ CSF is an abbreviation for cerebrospinal fluid.

26 ¹⁵ A shunt is a passage between two natural body channels, such as blood vessels, especially one created
surgically to divert or permit flow from one pathway or region to another; a bypass.

27 ¹⁶ Foraminotomy is the removal of the intervertebral foramen (an aperture or perforation through a bone or
a membranous structure).

28 ¹⁷ Facetectomy is the surgical removal or excision of a facet, particularly the articular facet (a relatively
small articular surface of a bone) of a vertebra.

1 operative report after it was transcribed.

2 C). Respondent further states, in his operative narrative, that "a week (sic) point in the
3 dura was visualized ... and repaired using 4-0 silk sutures. A shunt was created for CSF egress."
4 The creation of a shunt was also included in the operative report's list of procedures performed.
5 There is, however, no description why a shunt was necessary when Respondent's narrative states
6 he repaired the dura during the procedure. When questioned by the Board, Respondent admitted
7 that he did not create a shunt during the operation, and did not "know what ... [his statement]
8 means." Further, he had "no idea" what he was referring to when he dictated his report and had
9 no explanation why this information was contained in two separate portions of his operative
10 report (i.e., the list of procedures performed section and the narrative section). Respondent failed
11 to accurately dictate the procedures he performed during the operation and failed to correct his
12 operative report after it was transcribed.

13 15. Respondent committed acts of gross negligence in his care and treatment of patient
14 J.S. when he:

15 A). Performed unnecessary surgical procedures at L3 and L5-S1 without evidence of
16 severe stenosis or other findings justifying the procedures at these levels;

17 B). Excluded S1, the sacrum, from the instrumentation construct when attempting to fuse
18 the L3-S1 levels;

19 C). Documented that he performed various procedures during the operation which were
20 not performed; and

21 D). Repeatedly failed to adequately, appropriately and accurately document the patient's
22 chart.

23 **Patient M.S.**

24 16. On or about February 5, 2010, patient M.S., a then 64-year old female, presented to
25 the Ventura County Neurosurgical Associates (VCNA) for severe pain in her left lower extremity
26 and knee. M.S. was referred to another office for an epidural injection of her lumbar spine.

27 17. On or about February 18, 2010, M.S. returned to VCNA when the epidural injection
28 failed to address her concerns. Respondent saw M.S. and recommended surgery as soon as

1 possible.

2 18. On or about February 21, 2010, M.S. presented to the Community Memorial Hospital
3 (CMH) Emergency Department unable to ambulate. Respondent saw M.S. for a neurosurgical
4 consult and recommended surgery the following morning. However, Respondent's pre-operative
5 history and physical note failed to specifically detail what the radiologic findings were and which
6 levels were involved. M.S. signed a consent for a lumbar interbody fusion at L4-5 and a posterior
7 lumbar decompression and fusion at L4 to S1.

8 19. On or about February 22, 2010, Respondent performed surgery on M.S. at CMH.
9 Respondent's operative report lists that he performed a posterior "decompression at L4, L5, S1;
10 posterior lateral fusion L4, L5, S1; plate fixation L4, L5, S1" and "interbody fusion L5-S1."
11 However, the post-operative CT scan report does not support this and notes laminar defects at L4
12 and an interbody cage and hardware at L4-5.

13 20. M.S. was thereafter discharged and received physical therapy. Respondent saw M.S.
14 for a follow-up office visit on March 2, 2010, which was unremarkable.

15 21. In May 2010, M.S. presented to Respondent at VCNA to address the redevelopment
16 of some of her pain. An MRI revealed increased pathology at L4-L5.

17 22. On or about June 19, 2010, M.S., in preparation for surgery, signed a consent for an
18 interbody lumbar fusion of L5 to S1 with lumbar instrumentation. Respondent saw M.S. prior to
19 the surgery and dictated a history and physical note in the patient's chart. In that note,
20 Respondent states that M.S. had "a previous fusion from L4-L5." Respondent's plan was to
21 "perform a full discectomy and interbody fusion at L5-S1." However, Respondent had previously
22 decompressed, fused and instrumented L5-S1 four months earlier, according to his February 22,
23 2010 operative report.

24 A). Respondent lists, in his June 19, 2010 operative report, that he performed a
25 "Laminectomy for decompression of the nerve roots at L4, L5, S1; lumbar discectomy L5-S1;
26 posterolateral fusion L4, L5, and S1; pedicle screw fixation L4, L5, S1" utilizing the Apex
27 pedicle screw system. However, there was no documented diagnosis or justification requiring a
28 laminectomy and decompression at L4. Additionally, the L4 level was not included in the

1 consent M.S. signed. Respondent, however, failed to document any explanation for the
2 discrepancies between the actual procedures performed and the procedures listed in the signed
3 patient consent and testified that he did not review the signed consent form before the operation.

4 23. After the June 2010 surgery, M.S. developed right-sided foot drop and right leg pain,
5 a new post-operative neurological complaint.¹⁸ This should have prompted an immediate work-
6 up and imaging to determine the cause of the problem. Several months later, however,
7 Respondent ordered an Electromyography¹⁹ (EMG)/Nerve Conduction Velocity²⁰ (NCV) study.
8 The EMG/NCV was performed on November 23, 2010, and revealed malpositioning of the
9 pedicle screws at L4, L5 and S1.

10 24. Respondent committed acts of gross negligence in his care and treatment of patient
11 M.S. when he:

12 A). Failed to promptly evaluate and determine the cause of the patient's right-sided drop
13 foot and right leg pain, a new post-operative neurological finding; and

14 B). Repeatedly failed to adequately, appropriately and accurately document the patient's
15 chart.

16 **Patient R.S.**

17 25. On or about June 15, 2009, patient R.S., a then 57-year old female, presented to the
18 Ventura County Neurosurgical Associates (VCNA) for severe weakness in her lower left
19 extremity and foot, and numbness. R.S. was referred to Respondent for surgical consultation and
20 evaluation.

21 26. On or about July 22, 2009, Respondent saw patient R.S. and opined that she would
22 need a decompression with microdiscectomy at L4-5. Respondent advised her that the surgical
23 correction of her scoliotic deformity would not relieve her symptoms. At that time, R.S. decided
24 not to have the procedure.

25 ¹⁸ All of the patient's pre-operative symptoms and findings had been limited to the left side.

26 ¹⁹ Electromyography (commonly referred to as EMG) is a type of test in which a nerve's function is tested
27 by stimulating a nerve with electricity, and then measuring the speed and strength of the corresponding muscle's
28 response.

²⁰ Nerve conduction velocity test (commonly referred to as NCV) is a test that measures the time it takes a
nerve impulse to travel a specific distance over the nerve after electronic stimulation.

1 27. Thereafter, Respondent saw R.S. several times for follow up visits as she
2 contemplated surgery.

3 28. On or about June 18, 2010, R.S. had a CT scan of her lumbar spine which reflected
4 scoliosis with osteoarthritis and a prior anterior interbody fusion at L2-3.

5 29. On or about August 12, 2010, Respondent saw R.S. for another follow up visit.
6 Respondent scheduled her for a two-staged operation which included "a T12 to L5 anterior
7 release followed by a T4 to S1 decompression and fusion."

8 30. On or about October 19, 2010, R.S. presented to Community Memorial Hospital
9 (CMH) and signed a consent for a lumbar interbody fusion from T12 to L5 and lumbar
10 instrumentation and cages. At that time, R.S. also signed a consent for the second stage of the
11 surgery scheduled to occur the following day.

12 A). Respondent performed the first stage of the operation on R.S. In his operative report,
13 Respondent lists that he performed a "lumbar interbody fusion" from T12 to L5, an "interbody
14 cage placement, L4-L5, L3-L4," structural allograft in the interbody space, L2-L3, T12-L1,"
15 arthrodosis²¹/ instrumented fusion" from T12 to L5" with allograft and autograft. However, his
16 narrative description of the procedure does not describe the placement of any instrumentation as
17 referenced; only cages at L3-L4 and L4-5. Additionally, the post-operative CT report does not
18 note any hardware at these levels, only the interbody cages. Respondent, however, failed to
19 accurately dictate the procedures he performed during the operation and failed to correct his
20 operative report after it was transcribed.

21 31. On or about October 20, 2010, Respondent performed the second stage of the
22 operation on R.S. Respondent lists, in his operative report, that he performed a "posterolateral
23 fusion, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, L6, S1. Pedicle screw
24 fixation, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, L6, S1. Laminectomy for
25 decompression of nerve roots, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, L6, S1.

26

27 ²¹ Arthrodesis is the surgical fixation of a joint by a procedure designed to accomplish fusion of the joint
28 surfaces by promoting the proliferation of bone cells.

1 Partial vertebrectomy²²-corpectomy²³, T7, T8, T10, T12, L2, L4. Correction of scoliotic
2 deformity, thoracic, lumbar, sacral.” However, the consent R.S. signed does not include partial
3 vertebrectomies-corpectomies at any level, nor the correction of the patient’s thoracic, lumbar, or
4 sacral scoliotic deformity. Respondent told the Board that he does not look at the signed consent
5 before the procedure but goes off his own notes. There is, however, no explanation documented
6 by Respondent for the discrepancies between the actual procedures performed and the procedures
7 listed in the signed consent.

8 A). Respondent states, in his operative narrative, “that the patient has 6 lumbar
9 vertebrae.” This finding, however, is not documented in the lumbar CT scans reports, the lumbar
10 MRI reports, nor in Respondent’s operative report narrative from the previous day.

11 B). Respondent’s operative report further states that he performed laminectomies from
12 T4-S1 in order to facilitate de-rotation of the scoliosis curve. However, Respondent’s
13 documentation lacks sufficient specificity to justify laminectomies at all these levels.
14 Additionally, the post-operative lumbar CT scan reports a post laminectomy at L3-4, and states
15 that “other than the prosthetic device at L3-4, there are no extradural abnormalities appreciated.”
16 Had laminectomies of T4 down to S1 been performed, as described in Respondent’s operative
17 report, these findings should have been noted in the post-operative CT reports.

18 C). Respondent’s operative report narrative describes performing “osteotomies” “at T6,
19 T8, T10, T12, L2 and L4” which “entailed removal of the superior and inferior articulating facets
20 as well as drilling into the pedicle in order to allow for derotation of the curve.” This description,
21 however, is consistent with a pedicle subtraction osteotomy, not a vertebrectomy/corpectomy as
22 listed in his procedures performed section of the operative report. Had pedicle subtraction
23 osteotomies been performed, as described in Respondent’s operative report, these findings should
24 have been noted in the post-operative CT reports. Additionally, the post-operative thoracic CT
25 scan report states that notes that “despite the patient’s scoliosis the central canal remains well-
26 preserved.” Respondent failed to accurately dictate the procedures he performed during the

27 ²² Vertebrectomy is the excision of a vertebra.

28 ²³ Corpectomy is the removal of a vertebra body during spinal surgery.

1 operation and failed to correct his operative report after it was transcribed.

2 32. Respondent committed acts of gross negligence in his care and treatment of patient
3 R.S. when he:

4 A). Performed unnecessary surgical procedures at T4 to S1 without clear indication or
5 other findings justifying the procedures;

6 B). Documented that he performed various procedures during the operation which were
7 not performed; and

8 C). Repeatedly failed to adequately, appropriately and accurately document the patient's
9 chart.

10 **Patient D.B.**

11 33. On or about October 9, 2009, patient D.B., a then 24-year old female, presented to the
12 Emergency Department at Community Memorial Hospital (CMH) after having undergone a
13 lumbar puncture the prior evening to rule out a subarachnoid²⁴ hemorrhage. Thereafter, she
14 developed back pain and bilateral weakness of her lower extremities. An MRI of her lumbar spine
15 revealed an epidural collection of fluid in the vertebral canal anteriorly extending from L2
16 through S1, presumed to be a hematoma. The study also reflected no significant herniation of the
17 lumbar discs. Due to her complaints, a neurosurgical consultation was scheduled with
18 Respondent who saw her that day.

19 A). After consulting with D.B., Respondent scheduled her for the "emergent evacuation
20 of the epidural hematoma." Respondent's operative report lists that he performed
21 "Laminectomies L3, L4, L5, S1; posterolateral fusion L3, L4, L5, S1; repair of cerebrospinal
22 fluid leak; creation of shunt; evacuation of epidural hematoma; autograft." However,
23 Respondent's consultation report and operative narrative fail to document a clear indication for
24 performing a spinal fusion on this 24-year old woman. When questioned by the Board,
25 Respondent conceded that there was no clear indication to fuse the patient at that time.

26 ²⁴ Subarachnoid hemorrhage is bleeding between the pia mater (the innermost of the three meninges
27 covering the brain and spinal cord) and the arachnoid (a delicate membrane interposed between the dura mater and
28 the pia mater, separated from the latter by the subarachnoid space) of the brain.

1 B). The consent D.B. signed lists the procedure as lumbar laminectomy at "L1-S1 with
2 possible posterior lateral fusion." The consent does not include the evacuation of epidural
3 hematoma. Respondent testified that he does not look at the signed consent before the surgery
4 and relies on his own notes. However, Respondent failed to document an explanation in the
5 patient's chart for the discrepancies between the actual procedures performed and the procedures
6 listed in the signed consent.

7 C). Respondent's operative report states that he performed decompressive laminectomies
8 at L3 to S1. However, this is not supported by the post-operative lumbar MRI study report which
9 notes laminectomies at L4 and L5.

10 D). The narrative portion of Respondent's operative report states that the "dura was very
11 thin in its entirety and a large area of leakage was found. This was repaired and a shunt was
12 created to allow for passage of CSF." However, Respondent failed to describe why a shunt was
13 necessary since he repaired the tear during the procedure. When questioned by the Board,
14 Respondent admitted that no shunt was created during the operation and did not "know what that
15 [statement] means." Further, he had "no idea" what he was referring to when he dictated his
16 report and had no explanation why this information was contained in two separate portions of his
17 operative report (i.e., the list of procedures performed section and the narrative section).
18 Respondent failed to accurately dictate the procedures he performed during the operation and
19 failed to correct his operative report after it was transcribed.

20 34. On or about October 21, 2009, D.B. returned to the emergency room for the drainage
21 of her lumbar epidural hematoma.

22 35. On or about October 26, 2009, D.B. was readmitted into CMH for increased
23 serosanguineous fluid from her surgical wound, increased back pain and right sciatica symptoms.
24 An MRI revealed a new epidural hematoma extending from T11-12 through L2-3.

25 A). Respondent saw D.B. and scheduled her for the evacuation of the hemotoma that
26 day. D.B. signed a consent for an epidural hematoma evacuation of the lumbar spine. However,
27 Respondent's operative report lists the procedures as a "laminectomy, L1; partial laminectomy,
28 T12, repair of dural defect; evacuation of epidural hematoma." Respondent reiterated that he

1 does not look at the signed consent before the surgery and relies on his own notes. However,
2 Respondent failed to document an explanation in the patient's chart for the discrepancies between
3 the actual procedures performed and the procedures listed in the signed consent.

4 36. On October 28, 2009, a post-operative lumbar MRI report notes that the "epidural
5 hematoma has not changed" from the pre-operative image and "extends from the L3-4 level
6 proximally to approximately T11."

7 37. Respondent committed acts of gross negligence in his care and treatment of patient
8 D.B. when he:

9 A). Performed an unnecessary fusion of the lumbar spine without a clear indication or
10 findings justifying the procedures performed;

11 B). Documented that he performed various procedures during the operation which were
12 not performed; and

13 C). Repeatedly failed to adequately, appropriately and accurately document the patient's
14 chart.

15 Patient M.M.

16 38. On or about May 24, 2010, patient M.M, a then 58-year old female, presented to
17 Respondent at the Ventura County Neurosurgical Associates (VCNA) due to degenerative disc
18 disease, osteoarthritis and scoliosis. Respondent stated, in a letter to the referring physician, that
19 he told the patient if her symptoms returned he would "schedule her to undergo a minimally
20 invasive lateral correction of her scoliotic deformity supplemented by posterior pedicle screw
21 fixation." However, on that date Respondent completed a Surgery Scheduling Work Sheet noting
22 that the surgery date would be in "Mid July." The work sheet further listed a two-day staged
23 procedure as a "XLI7 L1-L2, L2-L3, L3-L4, L4-L5" and "posterior lumbar decomp./fusion" with
24 Nuvasive instrumentation, and a "T10 - L5" on the second day with Apex instrumentation.

25 39. On or about July 22 and 23, 2010, M.M. was scheduled to undergo the two-day
26 staged surgery, however, the surgery was rescheduled to the beginning of August as the patient
27 was not feeling well.

28 40. On or about August 5, 2010, M.M presented to Community Memorial Hospital

1 (CMH) and signed a consent for a anterior lumbar interbody fusion from L1 to L5 with
2 autograft/allograft and lumbar instrumentation. Respondent's operative report, however, does not
3 list or describe that an L1-2 anterior interbody fusion was performed that day. There is no
4 explanation documented in the patient's chart for the discrepancies between the actual procedures
5 performed and the procedures listed in the signed consent. When questioned, Respondent told the
6 Board that he does not review the signed consents before the procedure and probably never meant
7 to perform an anterior lumbar interbody fusion at L1-L2. Respondent, however, failed to
8 document this in the patient's chart.

9 41. On or about August 6, 2010, M.M. underwent the second portion of the staged
10 procedure. Respondent's operative report lists that he performed "Laminectomy for
11 decompression of nerve roots" from T10 to S1, a "posterolateral fusion" from T10 to S1,
12 "pedicles screw fixation" from T10 to L5, and correction of scoliosis at T10 to S1. The post-
13 operative x-rays and MRI reports, however, do not reflect laminectomies or fusions at S1, but
14 pedicle screws and wires from T9 down to L5.

15 A). Additionally, M.M signed a consent for a "lumbar decompression and fusion" of T10
16 to L5 with lumbar instrumentation. Respondent testified that he does not look at the signed
17 consent before the surgery and relies on his own notes. There is, however, no explanation
18 documented in the patient's chart for the discrepancies between the actual procedures performed
19 and the procedures listed in the signed consent.

20 B). Even though Respondent's operative report lists and described laminectomies and
21 fusions from T10 to S1, Respondent admitted, during questioning by the Board, that he actually
22 performed "laminotomies,"²⁵ not "laminectomies" as described and listed in his operative report.
23 Respondent failed to accurately dictate and describe the actual procedures he performed and
24 failed to correct his operative report after it was transcribed.

25 C). Respondent's operative report further lists and describes that the fusion extended to
26

27 ²⁵ A laminotomy is the excision of a portion of a vertebral lamina resulting in enlargement of the
28 intervertebral foramen for the purpose of relieving pressure in a spinal nerve root. A laminectomy is the surgical
removal of the posterior arch of a vertebra.

1 the S1 level. This, however, is not supported by the post-operative imaging studies which
2 reflected pedicle screws and wires from T9 down to L5. Respondent, however, failed to
3 accurately report this in his operative report. Additionally, when performing long segment
4 fusions for scoliosis correction that extends to or near the lumbosacral junction, the fusion
5 construct should incorporate the sacrum to avoid the creation of a lever-arm effect at the
6 lumbosacral junction. Respondent, however, failed to include the sacrum (S1) in the
7 instrumentation construct during the second procedures and failed to provide a clear rationale for
8 failing to do so. Respondent also failed to accurately dictate the procedures he performed during
9 the operation and failed to correct his operative report after it was transcribed.

10 42. Respondent committed acts of gross negligence in his care and treatment of patient
11 M.M. when he excluded the sacrum (S1) from the instrumentation construct when attempting to
12 perform a long segment scoliosis deformity correction surgery.

13 SECOND CAUSE FOR DISCIPLINE

14 (Repeated Negligent Acts)

15 43. Respondent is subject to disciplinary action under Business and Professions Code
16 section 2234, subdivision (c), in that that he committed repeated negligent acts in his care and
17 treatment of patients J.S., M.S., R.S., D.B., and M.M. The circumstances are as follows:

18 44. Paragraphs 11 through 14C, 16 through 23, 25 through 31C, 33 through 36, and 38
19 through 41C, inclusive, above are incorporated herein by reference as if fully set forth.

20 Patient J.S.

21 A). Performed unnecessary surgical procedures at L3 and L5-S1 without evidence of
22 severe stenosis or other findings justifying the procedures at these levels;

23 B). Excluded S1, the sacrum, from the instrumentation construct when attempting to fuse
24 the L3-S1 levels;

25 C). Documented that he performed various procedures during the operation which were
26 not performed; and

27 D). Repeatedly failed to adequately, appropriately and accurately document the patient's
28 chart.

1 **Patient M.S.**

2 A). Failed to promptly evaluate and determine the cause of the patient's right-sided drop
3 foot and right leg pain, a new post-operative neurological finding; and

4 B). Repeatedly failed to adequately, appropriately and accurately document the patient's
5 chart.

6 **Patient R.S.**

7 A). Performed unnecessary surgical procedures at T4 to S1 without clear indication or
8 other findings justifying the procedures;

9 B). Documented that he performed various procedures during the operation which were
10 not performed; and

11 C). Repeatedly failed to adequately, appropriately and accurately document the patient's
12 chart.

13 **Patient D.B.**

14 A). Performed an unnecessary fusion of the lumbar spine without a clear indication or
15 findings justifying the procedures performed;

16 B). Documented that he performed various procedures during the operation which were
17 not performed; and

18 C). Repeatedly failed to adequately, appropriately and accurately document the patient's
19 chart.

20 **Patient M.M.**

21 A). Excluded the sacrum (S1) from the instrumentation construct when attempting to
22 perform a long segment scoliosis deformity correction surgery; and

23 B). Repeatedly failed to adequately, appropriately and accurately document the patient's
24 chart.

25 **THIRD CAUSE FOR DISCIPLINE**

26 **(Dishonest and Corrupt Acts)**

27 45. Respondent is subject to disciplinary action under Business and Professions Code
28 section 2234, subdivision (e), in that committed dishonest and corrupt acts in his care and

1 treatment of patients J.S., M.S., R.S., D.B. and M.M. The circumstances are as follows:

2 46. Paragraphs 11 through 14C, 16 through 23, 25 through 31C, 33 through 36, and 38
3 through 41C, inclusive, above are incorporated herein by reference as if fully set forth.

4 FOURTH CAUSE FOR DISCIPLINE

5 (Failure to Maintain Accurate and Adequate Records)

6 47. Respondent is subject to disciplinary action under Business and Professions Code
7 section 2266 in that he failed to maintain adequate and accurate records in his care and treatment
8 of patients J.S., M.S., R.S., D.B., and M.M. The circumstances are as follows:

9 48. Paragraphs 11 through 14C, 16 through 23, 25 through 31C, 33 through 36, and 38
10 through 41C, inclusive, above are incorporated herein by reference as if fully set forth.

11 PRAYER

12 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
13 and that following the hearing, the Medical Board of California issue a decision:

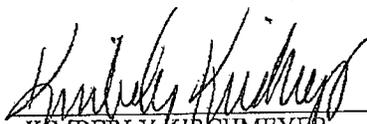
14 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 108433,
15 issued to Aria Omar Sabit, M.D.

16 2. Revoking, suspending or denying approval of his authority to supervise physicians
17 assistants, pursuant to section 3527 of the Code;

18 3. If placed on probation, ordering Respondent to pay the Medical Board of California
19 the costs of probation monitoring; and

20 4. Taking such other and further action as deemed necessary and proper.

21
22 DATED: November 5, 2013


KIMBERLY KIRCHMEYER
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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